TROPICAL DERMATOLOGY

TYPE 1 REACTION IN BORDELINE LEPROMATOUS LEPROSY MISDIAGNOSED AS A RHEUMATOLOGIC CONDITION IN AN ENDEMIC COUNTRY.

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Background: Leprosy is a chronic infectious disease that affects mainly skin and nerves. It has a chronic course but can present acute inflammatory episodes known as leprosy reactions, which exhibit symptoms that may mimic a rheumatologic condition. We present a case misdiagnosed as rheumatoid arthritis (RA) and systemic lupus erythematosus (SLE)

Observation: A 35-years-old man with a 2-year history of paresthesias, arthralgias and a positive rheumatoid factor was diagnosed as RA and treated with chloroquine and sulfasalazine without improvement. Six months later, he developed widespread pruritic skin lesions and arthritis. Antinuclear antibodies and anti DNA were positive which led to the diagnosis of SLE and he was treated with methotrexate and prednisolone for 18 months with no therapeutic response. Later he was admitted with sudden edema, increase in the number of skin lesions, burning sensation and worsening of previous symptoms. Hansen disease was suspected, bacterial smears were positive, bacterial index: 1.3 and a skin biopsy confirmed leprosy. Treatment with multidrug therapy (MDT) and prednisolone 50 mgs daily was started. Two months later he attended our leprosy clinic with worsening of symptoms. On examination, he had widespread brownish macules, hypoesthesic erythematous annular plaques with elevated borders and central clearing, posterior tibial nerves were enlarged and tender. New skin biopsy was performed and showed a perivascular, endoneural and lymphohistiocytic infiltrate forming dermal granulomas, Ziehl Nielsen stain was positive for acid fast bacilli. The final diagnosis was type 1 reaction in borderline lepromatous leprosy. After 9 months of MDT and prednisolone treatment his condition has improved dramatically.

Key message: Leprosy reactions may present with systemic symptoms, arthritis and skin lesions, mimicking rheumatologic conditions. False positive ANAs and rheumatoid factor may be present. Physicians need to be aware of this condition to avoid unnecessary treatments, delayed diagnosis and prevent permanent nerve damage.